UNITED NATIONS

World Chronicle

PROGRAMME: No. 639, recorded 10 October 1996

GUEST: **Pamela HARTIGAN**
Regional Coordinator
Gender, Health and Development Program
Pan American Health Organization (PAHO)
WHO Regional Office for the Americas

JOURNALISTS: Judy Lessing, Radio New Zealand
Ricardo Alday, Mexican News Agency

MODERATOR: Michael Littlejohns

WOMEN'S HEALTH AND DEVELOPMENT

Pamela HARTIGAN, Regional Coordinator of the Gender, Health and Development Program of the Pan American Health Organization, the World Health Organization's Regional Office for the Americas. Ms. Hartigan discusses the need for health care for women as individuals rather than simply as mothers. She stressed that, for both men and women, gender roles, not just biology, play an important part in contributing to causes of illness as well as in determining specific treatments. Equity among all different groups is the cornerstone of PAHO's work. One third to one half of the women in Latin America are victims, or survivors, of domestic violence. Indigenous women need special and specific strategies to be fully integrated into health and social development.

WORLD CHRONICLE is produced by the Media Division, Department of Public Information, United Nations, New York, NY 10017, U.S.A.

Duration: 28:00"
Executive Producer: Kamil Taha
Director: Livingston Hinckley
Production Assistant: Ellen McGuffie

ANNOUNCER: From United Nations Headquarters in New York, this is **World Chronicle**, an unedited interview programme about major global issues. Here now to introduce our guest is the host of today's **World Chronicle**.

LITTLEJOHNS: I'm Michael Littlejohns, and this is **World Chronicle**.

Until recently, the issue of women's health as mothers rather than individuals has been the focus of health policy-makers all around the world. As a result, not enough attention is given to helping women live healthier and better lives throughout their life span. This trend has deprived women, particularly in many third world countries, from access to and control of resources needed to promote and protect their health. What can be done to bridge the gender gap? And how can women become more equal partners with men in shaping the health, economic and human development of their societies?

Our guest today, Pamela Hartigan, is the Regional Coordinator of the Gender, Health and Development Program of the Pan American Health Organization, PAHO, Regional Office of the World Health Organization. Joining me to talk with Ms. Hartigan are Ricardo Alday of the Mexican News Agency and Judy Lessing of Radio New Zealand.

Ms. Hartigan, welcome to World Chronicle.

HARTIGAN: Thank you very much.

LITTLEJOHNS: Are we talking here about health problems for women across the board, all kinds of ailments, or are we concentrating mainly on diseases and infirmities peculiar to women, like uterine cancer, breast cancer? Of course men can get breast cancer too, if it comes to that, but it's more common with women. Is that what we're talking about, or is it everything?

HARTIGAN: We're talking really about both things. We're talking about diseases, but not just diseases, also how to promote health for men and women and how that can be different, and diseases that affect both men and women, specifically how they affect them differently because of their gender roles. And we're also talking about diseases specific to women that have for too long also not received proper attention, like cervical cancer, for example, and other such illnesses that women peculiarly have. But we're also looking at what we call how gender roles and the value that's attached to those gender roles have a differential way of having an impact on the chances that women and men will become ill and die from a preventable disease. I'll give you a very specific example. We know, for example, that men die much more frequently from violence or from cirrhosis or from accidents. And our feeling is that many of those deaths actually could be avoided with some modification of gender-expected behaviour—you know, the issue of risk-taking, the issue of trying to be aggressive or solving problems aggressively. So those are gendered behaviours in men that definitely have a negative impact on their health. So we're interested really in both those

issues, the issues that are specific to women's health, but also issues that have to be looked at through a gender lens. Although I must hasten to add that women's issues specific to women's health also have to be looked at through a gender lens, but also we're interested in what makes—

LITTLEJOHNS: So how are you tackling it? Is it a matter of raising consciousness of women's health problems?

HARTIGAN: Correct. That and also the fact that—I suppose the most concrete example that I can give you is that when I actually came into the program about three years ago I didn't really understand the issues. My background is not in women's health, I'm an economist. And then I got a Ph.D. in clinical psychology, and I had worked in the NGO world for many, years.

LITTLEJOHNS: Non-governmental organizations.

HARTIGAN: Non-governmental, exactly. And I came to PAHO, Pan American Health Organization, to help with some behavioral research on AIDS-HIV, and worked with the NGO community on that, and from there I was asked to take over the women's programme, to which I immediately said, no way. I don't like women's programmes, I've never liked women's programmes.

LITTLEJOHNS: You're not a feminist, is that it?

HARTIGAN: That's not the issue, I think I'm very much a feminist. The problem was that I always found that women's programmes were headed by some poor soul, always a woman, who had no resources, no backing, and it wasn't taken seriously by the organizations in which she worked. And I say she, because she was usually alone, there was no staff. And I really—I guess I felt that I'd worked too hard to not be taken seriously. So the agreement with the then-director was that I would do the task, or try to actually build up the programme, but that one of the approaches that we would take would be what we call mainstreaming a gender approach in all aspects of the work that PAHO does in health and development.

LITTLEJOHNS: That sounds a little bit—if I may say so—a little bit of gobbledy-gook. What does it really mean?

HARTIGAN: Yes, exactly. Good for you. It is, as I saw it, a bit of gobbledy-gook as well. What it means basically is that when we look at the issues that affect men and women's health, we are interested in finding out—it's an approach that helps us understand what's the interaction between biology and psychosocial development, or what we call gender development, and how that interaction has an impact, either negative or positive, on men's health or women's health, and how that interaction also can help us link into ways of preventing those diseases. Again, I'll give you a specific example: the issue of maternal

mortality. Many people say, what's the gender issue in that? How can maternal mortality—women are the ones that have babies, and that is biological. That's correct, but the fact that women die in childbirth is not just a biological issue, it's also a gender issue. And when we talk about a gender issue, we're talking about a perspective that allows us to identify, in order to change, situations that can be creating or maintaining inequities in health simply due—pertaining to one sex or the other, if I make myself clear. So that's what we try to get our people within PAHO to do, is to say I work in environmental health, how is it that a woman's traditional gender role, for example as a housewife, is actually having an impact on her health? Maybe through, you know, toxics in actual cleaning fluids that she's using, or having to carry fuel, or whatever. How is that? And how are men's gendered roles? If they're out in the fields and they're having—you know, why do they get more malaria? Well, obviously because the division of labour is such that men work in the fields. So we try to get our people to begin to understand that it's not just a matter of biology. And why does that matter? The whole cornerstone of what we do is based on equity. And when we talk about equity, we're talking about the fact that different people, different groups have need different things, and that we need to identify those differences in order to be able to address them specifically. So you're not going—and in fact it's very important to note that not all women are alike, and not all men are alike, so even within the very specific communities that they live in you also have to look at how those gender roles are played out within each community.

ALDAY: And then what have you found to be the most challenging, the main challenges of your work in a region so diverse as the Americas?

HARTIGAN: I think that the most—if by challenging you mean difficult, I guess I—challenging means fun to me as well—I guess—

LITTLEJOHNS: Challenging means what?

HARTIGAN: Fun.

LITTLEJOHNS: Fun! Oh, well, that's good. That's a good attitude.

HARTIGAN: I think that the most challenging thing has been to technify what has been a political statement. And what I mean by that is the following: I think that—you know, you asked me if I was a feminist. I think feminism in Latin America is a dirty word, a little bit like liberal in the United States seems to have become. But I think that what we have tried to do is to say this isn't feminism, this is an issue of equity and this is an issue of actually looking at how we, as PAHO, can improve the health of men and women. And if we don't look at what makes that man or that woman healthy or become ill, then we're not doing our job. So let's look at ways to do our job better. And the most challenging thing has been to convince medical doctors that this is a valid approach. And I think that's the

most rewarding too, is that they are increasingly understanding that they cannot only look at biological components.

ALDAY: And have you found a resistance from women in the Americas? Culturally, I mean. Because of the long-standing tradition of a more submissive role of the woman in these societies?

LITTLEJOHNS: Machismo.

HARTIGAN: Yes. I wouldn't say resistance. Maybe, I think—you know, fear of change always creates resistance. But I think that more than anything it's feeling a little—it's feeling that they wish they could change it but they're not quite sure that they can. And maybe this is okay for their daughters, but not for them. We've found a lot of this in HIV, for example, when you talk to women in reproductive age, when you talk to them about negotiating condom use or talking to their male partner about negotiating condom use, they find that just the most ridiculous thought in the world. And they—

LITTLEJOHNS: You mean the male's attitude? Or the female?

HARTIGAN: Both, both attitudes.

LITTLEJOHNS: Both.

HARTIGAN: In other words, they do not see how they could possibly ask their male partners to wear condoms.

LITTLEJOHNS: Really?

HARTIGAN: Yes. Because it's a relationship, you know, between the two. And I certainly understand that. But it's okay—you know, they can see that perhaps in the next generation. And I think that that's the most frustrating for me, is to see how women already in Latin America at 30 feel that they've lived their lives. There is a tremendous emphasis on youth. We think that it's characteristic of the United States, but I think that women over 30 already think that they're old. I don't know if, you know, being a Latin American you would agree with that, but that's what I find.

LESSING: You talked about changing attitudes. The health field is traditionally dominated by men. Can you encourage more women to enter it? I mean, there is a level of good education in Latin America. Can you persuade some of those women that perhaps the health field is something where they can have a good job and also help?

HARTIGAN: Yes. In fact, I suppose that right now—of course, as you know, nurses are mainly women. And more and more women are joining the medical profession. I think right now in some medical schools really it's 50-50, in Latin America. The thing that's depressing to me is to find that the women who go through the medical training are gendered in the same way as the men are. In other words, the gender issue doesn't necessarily pertain to sex. This is very important. You can have women who act like men,

we all know that, and men that have, you know, have ways of behaving that are more feminine, or more what we traditionally think of as feminine. And women having gone through the medical training in fact become more gendered like their male counterparts. And I think that what needs to happen is a change in the curriculum. There needs to be a curriculum—

LITTLEJOHNS: When you say more gendered, do you mean that they take a less sympathetic attitude to women patients?

HARTIGAN: That's part of it. We find—for example, right now we're doing a very interesting study on quality of care in several of our countries in the region, and we're looking at the interaction between the health provider and the male or the female patient, and we're in fact finding what we wanted to see. There's been a lot of work in this in the area of reproductive health, but of course men don't go to reproductive health services. So we were interested in finding whether for the same illness men and women were treated differently, say diabetes or hypertension. So we took the same illness and we developed an instrument whereby what we actually did was, through observations, anthropological techniques, observe the interaction and talk, interview with the doctors, male and female doctors. And we have found quite surprising differences in the sense that women do have a much longer waiting time—if a man comes for attention a man is seen even if the woman has been sitting there for quite a while. Women are always alone, but the husbands always go accompanied by their wives. So in the case of a diabetic, the doctor, be it male or female, will usually address the dietary recommendations to the woman, who's sitting with him, and she will make sure that the dietary conditions are met at home. But the woman diabetic goes alone, and she doesn't take specific care of herself. It implies a whole other set of, you know, expenses in terms of purchasing of food or cooking special foods for herself, and women aren't geared towards looking after themselves very well. They're better geared towards looking after others. That's a gendered role.

LITTLEJOHNS: This is **World Chronicle**. Our guest is Pamela Hartigan, Regional Coordinator of the Gender, Health and Development Program of the Pan American Health Organization, Regional Office of the World Health Organization.

ALDAY: What about the role of the church? How important is it, and how an obstacle or a help is it in your endeavours?

HARTIGAN: That's a question that I often get asked. I guess there's a connection between the fact of reproductive rights and sexual rights and the church in Latin America. It sort of seems like a combination that could be difficult. We have not specifically worked with the church as an organization, but we do work with individual clergy of the church. And we've had wonderful, wonderful experiences, especially at the local level. And I'll give

you very specific examples. We have a major initiative in violence against women in 17 countries of the region, and it's very directed towards the local level. And what it seeks to do is to create community networks that are able to respond in a coordinated fashion to an issue of domestic violence. And by domestic violence—and I'll be talking about that later on today—and in the issue of domestic violence we're looking at psychological, physical and sexual abuse. And one of the issues comes to—what we're trying to do is to get together a network of all the actors that would have anything to do with violence or responding to violence. And here the church has a big role, because we find that they can play a very important—they're a very important factor, especially with male batterers. You know, in terms of—

LITTLEJOHNS: Excommunicate male batterers?

HARTIGAN: No, actually work with them. I think male batterers are as big a victim of violence, of domestic violence, as the women that they abuse. And they have a very important role in that. You don't work with the church to promote condom use, you just know—you need to know what to ask the church to help you with. And we have been extremely fortunate in terms of that. I think, sure, we get frustrated about some of the obstacles, but in general we've had very, very—we've been very fortunate.

LESSING: You're talking about violence. Is it a really—is domestic violence a major problem in most of the countries of Latin America?

HARTIGAN: It is. It is an absolute epidemic. The thing that is difficult to know is whether this always existed and has now become a public problem, a public health problem, or whether in fact, you know, it is increasing the way other types of violence are increasing. I suspect, having been born and brought up in Latin America, that it's always been there. I certainly remember many cases of it as I grew up, but of course one tends to always focus on your own experience. We know of and have done several prevalence studies, and we find that, similar to the United States, one in three women is a victim of—well, I should say a survivor of domestic violence, and in some cases as many as half. A study that was just done in Leon, Nicaragua, which is a department in Nicaragua, sampled a random sample of 488 women, and they found that half that sample had suffered severe battering in the last year by an intimate male partner.

LESSING: There are examples—I don't know directly about Latin America, but I know about some of the countries of the Pacific, and there are women you talk to there, and they talk about domestic violence, and there is a level beyond which they will not accept it, but there is a level of acceptance, which surprises me, because I didn't grow up that way.

HARTIGAN: Correct. Yes, exactly.

LESSING: Is that the—

HARTIGAN: Very much the same. Very much the same. Women in Latin America – now, of course I'm generalizing, and it also depends on the cohort, because we find younger women are much less tolerant, you know, to put up with this than older women, but, in general, women expect their husbands to beat them. In general, women do. And when it happens they're not surprised. They want him to change; in general they don't want to leave the relationship, whether in fact or not they are economically independent. I find it's very important to always emphasize that it's not just an issue of poverty, it's very much an issue – it's a very complex issue.

LITTLEJOHNS: You mean it applies with middle class women too?

HARTIGAN: Oh, very much so.

LITTLEJOHNS: Really?

HARTIGAN: Very much so. And upper class women. We just don't –

LITTLEJOHNS: Upper class women too?

HARTIGAN: Oh, absolutely.

LITTLEJOHNS: Really?

HARTIGAN: There's another issue too that I think would be interesting –

LITTLEJOHNS: I mean, you're talking about Latin America now.

HARTIGAN: Yes, I'm talking about Latin America and the Caribbean. Absolutely. I think that of course upper class women have other ways of getting out of the situation, but I have – I know of many cases of women who had all the means to walk out but couldn't. I think, you know, I think as women –

LITTLEJOHNS: Family loyalty?

LESSING: They just couldn't bring themselves, or –

HARTIGAN: Yes. Yes, they couldn't bring themselves to do it. There's a whole network, there's a mystique about the family, and it's scary to do something like that, you know. And we haven't been raised in Latin America to be particularly confident in terms of making it alone. There's a tremendous relationship –

LITTLEJOHNS: What is the church's attitude? I mean, the church does not approve of divorce, so presumably they would not condone a wife walking out on a man.

HARTIGAN: Right, right, I think you're right. I've never really asked that question, but I think you're probably right. I know that in the United States a woman who is being battered is told to get out of the house, and to really think seriously about separating or leaving. It's a little bit different in Latin America. In Latin America what they see has to happen is to save the relationship. And they work very hard to save the relationship. And it's a different approach. It's a different approach. I mean, we might have our views as to

what we think would work or not work, and I've had to learn that you just have to respect the way they do things.

ALDAY: What about this regional wave of economic integration in the region? Is it doing any good for your work?

HARTIGAN: That's a very good question, and we don't know. We are trying to—we have a couple of baseline studies. Specifically, we're about to initiate a baseline study to look at the health and demographic changes as a result of economic integration along the US-Mexican border. And what we're basically collecting is data on all aspects, not just of morbidity and mortality, but issues of quality of life as well. That would include violence against women, that would include women in senior positions of management in industry and government sectors. And men, by the way. Looking at both sexes. And we're going to see if we can measure over time.... We don't know enough. We do know that, of course, integration implies a lot of movement of goods and services and human beings along the borders. We know that that has an impact on the choices that families make as far as having children, not having children, delaying children. We know that women are increasingly joining the work force, and certainly along the Mexican-US border we have the *maquilas* and we know that those majorly employ women. Some have very good working conditions, some have very bad working conditions. And so we don't know enough. But we suspect that this is going to have a very strong impact on women.

We know in Chile, for example, that women are taking—there is more work paid out to the home; in other words, women who are employed in the cloth industry actually take piecemeal work home, and of course there are no social security or—what would you call them?—insurance benefits available to those women. And those women live in very precarious conditions, and they have to split their domestic responsibilities with their productive responsibilities.

LITTLEJOHNS: Excuse me, Judy, just a moment.

LESSING: That's all right.

LITTLEJOHNS: Ms. Hartigan, let me just ask you about your relationship with WHO. I mean PAHO's relationship with WHO.

HARTIGAN: Yes, yes, that's a good question too. We get asked that a lot. PAHO was founded in 1902 as the inter-American organization that specialized in health. And it basically was an initiative on the part of the health ministries to come together to combat diseases. And then in 1948, when the UN system came into being and WHO was founded, WHO went and sought to set up regional offices. But when it came to the Americas it found that what was then the Pan American Sanitary Bureau was already doing what it needed a regional office to do. So they entered into an agreement whereby PAHO would be

the Regional Office of WHO in the Americas, but we also have a separate identity, which is as an inter-American organization. And that is a very, very strong, important part of our identity. You know, we're definitely part of WHO, but we also—we have—I guess we're schizophrenic.

LITTLEJOHNS: Forgive me, Judy, but I wanted to ask that question.

LESSING: That's fine. I was just curious, I wanted to go back to the question of what is politically and socially possible. Do women in Latin America in general have reasonably long lifespans? And if they don't, is this affected by health? And if they had longer lifespans would it be better for the economy? That's a lot of questions all in one.

HARTIGAN: Yes, yes. Women are living much longer. In general, women live longer than men. I was surprised to find that somebody that I knew didn't know that, and that—so I'll say that, even though most of you probably know that. And women are living much longer than men in Latin America. I think probably—it depends, of course, on the country. In Haiti you'll find a much shorter lifespan, you know, but in other countries you'll find.... And in the Southern Cone Countries* the lifespan is, you know, 70, 80s. This presents some very serious challenges, which aren't fun, to—

LITTLEJOHNS: Economic challenges.

HARTIGAN: Economic and social challenges. Because in fact by the age of 70 most of those women are living alone. You know, they're living alone, and it is going to place a tremendous strain on a social service system which is being increasingly privatized. You have to remember that in Latin America as a result of economic restrictions that have been felt world-wide, even here in this country, services are being increasingly privatized, but you have a very large proportion of the population who are living in poverty and cannot pay for services. This is a very worrisome trend. I mean, the demographic changes coupled with the economic and social changes are really creating a very frightening scenario from my point of view for the quality of life and the health of older people.

ALDAY: How do you deal with the indigenous women? Do you need a special strategy for them, or special programmes for that specific sector?

HARTIGAN: You know, we have for the past four years had a project in Guatemala with indigenous women. And it has been a very important learning experience for us. I think it is—yes, the answer is yes. Of course you need very specific strategies for dealing with indigenous women. But what I'm very frightened of is the typical health approach, which is, "These women don't know anything, and let's teach them about our wonderful medical system", when these women have an awful lot of traditional knowledge, and in fact

---

* Argentina, Brazil, Paraguay, Uruguay.

the contribution that they can make to prevention is extremely important. The issue of autonomy in indigenous cultures for women is a very difficult one. You definitely go in as a western feminist, and you have to respect the way that their gender roles are carried out.

ALDAY: So what is the best way to approach them?

HARTIGAN: The best way is really to make sure that you—I mean the only approach that I would recommend is that you foster the relationships by—I think you can't work with indigenous populations from the outside; you have to live in the community, you have to be part of the community. And the best thing that I think we can do is just to support and actually fund, channel the resources to help the people that know how to build those relationships and who are from that area to do that. I really feel very reticent about sending people in from the outside. And we do a lot of that; we do a lot of that. And that's been.... And even within a country like Guatemala, where there are difficulties, even the health system is foreign enough to the indigenous ways of doing things that the building needs to be done by someone who's probably even of the indigenous and has sort of a fringe person on either side of the...you know.

LITTLEJOHNS: Ms. Hartigan, that's a very interesting subject, and we wish we had a little more time to devote to it. But that's all the time we have. Thank you for being with us on this edition of **World Chronicle**.

Our guest has been Pamela Hartigan, Regional Coordinator of the Gender, Health and Development Program of the Pan American Health Organization, a Regional Office of the World Health Organization. She was interviewed by Judy Lessing of Radio New Zealand and Ricardo Alday of the Mexican News Agency.

I'm Michael Littlejohns. Thank you for joining us. We invite you to be with us for the next edition of **World Chronicle**.

* * * * *

Transcripts of the programme may be obtained free of charge by sending a stamped, self-addressed envelope to: **World Chronicle**, United Nations, Room S-827, New York, New York, 10017, USA.

World Chronicle is broadcast worldwide and features guests whose work is concerned with major global issues. This programme is a public affairs presentation of this station from United Nations Radio and Television.

Additional information material about the United Nations can be obtained by writing to Public Inquiries Unit, United Nations, Room GA-57, New York, New York, 10017, USA the UN Information Centre in your country.